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ABSTRACT

A referral system was developed to facilitate the work of a psychologist from a regional center in a rural area. Training in identifying behavioral characteristics of exceptional children was given to professionals and to lay persons, including parents. As a result, referrals increased 8%, with student, parent, and teacher referrals increasing and principals and regional center staff referrals decreasing. Also, a standard referral form was developed. Treatment provided included behavior modification, group and individual therapy, and family counseling. (JD)

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IDENTIFICATION, REFERRAL AND TREATMENT OF THE EXCEPTIONAL CHILD IN A RURAL AREA

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BY

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(Prepared for APGA, 1970)

Because of the time involved in traveling long distances, a rural psychologist, of necessity, must rely on other professional and lay persons to make the initial referral. It therefore was necessary to develop a referral system that would permit referrals to originate from several sources in the community. The first step in this process was to acquaint or train other professional or lay persons with the behavioral characteristics of the exceptional child in an effort to aid them in the early identification of these children. Therefore, several on-going training programs were established during the first and second operational year, such as: 1) a twelve-week teacher in-service training program for teachers, principals and counselors; 2) community family relation workshops for parents; 3) workshops for high school students; 4) panel discussions for students; 5) monthly coordinating and in-service training meetings were held for professional personnel from other agencies. In addition, we also found that providing panel discussions, participation in PTA's and civic clubs and church organizations were successful means of providing information to parents and others regarding when and how to refer a child for help.

The effectiveness of these training programs was measured by the number of referral increases in the 1968-69 school year as compared with the previous year. There were 394 students referred during the first 8 1/2 months of the 1968-69 school year as compared to 364 during the previous year. This

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represented an 8% increase. The effectiveness of the training program, however, was measured not only by the percent of increase in referrals but also by the source and quality of these referrals. For example: during the 1968-69 school year, the number of self-referrals from students increased by 400%. Parent referrals increased by 30%; teacher referrals were increased by 50%; referrals from other agencies increased by 16%, whereas referrals from principals decreased by 518% and referrals by the Regional Child Study Services (RCSS) staff members decreased by 66%. A substantial increase therefore was shown in the number of referrals from students, parents and teachers and a substantial decrease in the number of referrals from principals and staff members. This seemed to be an indication that parents and teachers were becoming more aware of correct referral procedures and/or the services offered. A large percentage of the referrals by principals were made after individual consultation with the school psychologist and following his recommendations; thus the decrease in staff referrals and principal referrals, as well as an increase in referrals from other sources, gave the school psychologist more freedom in the treatment of these cases rather than being involved in their initial identification and referral. Quality of referrals, that is being able to describe the behavioral characteristics of the exceptional child, was improved because of the increased ability of lay persons and professionals to recognize a variety of problems and their behavior symptoms.

In an effort to aid individuals who make referrals, and to provide the RCSS staff with specific information that would be useful in assigning the referral to a staff member and aiding in the diagnosis of the referred child,

a standard referral form was developed specifically to provide us with: 1) descriptive data about the child; 2) the name of the person making the referral; 3) the reason for referral; 4) the urgency of the referral as indicated by the principal or counselor.

The descriptive data provides information such as the child's name, age, birthdate, school, grade, and the parents' name, address, phone number and occupation.

The name of the person making the referral provides us with a source of further information regarding the child's behavior.

When giving the reason for referral, we ask the person making the referral to describe the action of the child in behavioral terms, such as describing what the child is doing rather than giving generalities.

A behavioral description of the problem also provided us with information needed to understand the nature of the referral so that when traveling to outlying areas we can take with us those diagnostic instruments we feel will aid in the identification and diagnosis of the referred child.

Asking the principal or counselor to indicate the degree of urgency of the referral--"extreme," "serious," or "moderate"--helps us in screening referrals for diagnosis. We found that because of the number of referrals received, it sometimes was necessary to postpone diagnosis and treatment of less critical cases. This method provides both the principal and our staff an opportunity to screen the referrals and to work with those individuals who appear to have the most severe problems.

Also printed on the referral form is a request for the date that parent approval is given and the initial of the person contacting the parent. We

find this item very helpful in that parental permission is necessary in order to conduct certain types of therapy with the student client, and it also provides a means of insuring that parents are made aware that the child has a problem and that help is available.

The referral form first used (which proved to be ineffective) was a full-page sheet asking for case history information about the client. With feedback from principals, counselors, teachers and other individuals making referrals, the RCSS staff revised the form so that it could be used by various agencies, providing the information necessary for the referral but eliminating the cumbersome time-consuming information that could better be gained through other sources or personal interviews.

Treatment of the exceptional child in the rural area depends, of course, upon several factors, many of which are similar to those of the urban area. However, there are additional factors involved such as the availability of the client's parents, the number of professional people in the area, and the availability of other agencies that could be helpful in the treatment process of the exceptional child.

Because of these factors, we have found that behavior modification therapy (BMT) is the best frontline or first approach when dealing with exceptional children in rural areas. BMT, we have found, brings about quick, as well as long-lasting, changes in the child's behavior without consuming a great amount of therapist time. With this approach, the therapist's role is more of a consultant to parents and teachers who are employed as the change-agents.

When using behavior modification, an individualized reinforcement

program can be designed with the help of the therapist and carried out by the teacher, principal, or parent, as well as by other significant individuals in the child's environment. This is done after the initial diagnosis of the problem has been made and the program has been discussed with the individual who will carry out the treatment. Many times the follow-up of the treatment programs can be done by correspondence or on the telephone, thus saving the therapist a great deal of expense and time in traveling to outlying areas.

Behavior modification, however, loses its effectiveness when cooperation is lacking from individuals who are significant in carrying out this treatment method. Often parents are not willing to invest the time and effort needed to modify their children's behavior. Teachers complain of their workload or the lack of facilities, remedial personnel, and other supporting programs, and are sometimes resistive to the request to carry out additional programs with their students. If for some reason we cannot establish an effective BMT program with a referred child, a second approach used by the RCSS staff in dealing with the exceptional child is group counseling. This has been effective in our rural areas because group work also saves some time--a lesser consideration, but still a consideration. Also, we have found that by placing the rural child in a group where there is a great deal of social awareness among members of small communities, it provides a better learning experience, particularly when dealing with problems of a social nature.

We have experienced success in group counseling modeled after the Human Potential Seminar Method, wherein strengths, weaknesses and goal-setting are discussed for each individual in the group. Some of the most

successful levels in this method have been those in grades five through seven. Groups using this method in which older students were included tended to exhibit less constructive behaviors. This may have been due to other dynamics at work in the groups. Three marathon confrontive group counseling sessions were held from twelve to fourteen hours in duration with good results, as anticipated, in a follow-up survey taken immediately following, and approximately three weeks after the sessions. In this survey, parents reported noticeable positive behavior changes in their children. In small communities, confrontation methods in groups appeared to be more threatening to the members and made it more difficult for them to discuss problems and feelings, especially after the first or second session. Although no research was conducted on this point, it appeared to be directly connected with the problem of confidentiality among the participants, especially in areas where everyone in the group knew each other's parents.

A group method for elementary children found to be acceptable and applicable to rural areas was a combination of play therapy and confrontative therapy. In this method, the children would have some physical or mental activity that required frequent social interaction, such as a game followed by "talk time," or in some cases together with a "talk time," or preceded by a "discussion time."

Group behavioral modification techniques like those advocated by John Krumboltz, et. al., in which individual group members were asked to pinpoint problems and carry out assignments, either on an individual basis or with some member of the group, appeared to work more effectively, partly

because the therapist was able to meet in group therapy only once during the week and the assignment given to each member provided him with an opportunity to work specifically on some aspect of his problem before the next session.

Family counseling was employed only when observable movement did not result from BMT or group therapy. Even though family counseling has proved to be an effective means of dealing with the exceptional child, particularly if the inappropriate behavior is observed both at school and in the home, it is difficult to meet with families on a regular weekly basis in outlying areas because of difficulty in meeting with parents. For example: it was difficult for me to meet with a family in an outlying community until 8:00 or 8:30 p.m. and then drive for two or two and one-half hours before arriving at the central office and my home. Because of this problem, and the lack of facilities to meet with families in the evening, we found it more effective to combine BMT with family counseling when using this approach to problem-solving.

Individual therapy, another effective means of dealing with the exceptional child, was used by our staff when we felt that an equal or better learning experience could not be provided through other means of counseling. Some members of our staff are currently becoming more involved in using hypnotherapy. Hypnotherapy appears to be helpful when dealing with certain types of anxiety that hinder the learning experience. However, because of community reaction to this type of therapy in some of the small and more provincial communities, it is used only with the permission of the parents, and usually in their presence. However, it is gaining more acceptance as a treatment method. Effectiveness of the treatment was

determined by obtaining a pre and post objective measure of observable behavior. A second means of obtaining data concerning the effectiveness of treatment was to have the referring person complete a follow-up evaluation of the progress of the child. A standard follow-up form was designed to be mailed to the referring person who could indicate the progress of the child and to what extent the recommendations were carried out. This method was used in conjunction with the more objective method mentioned above, or when the more objective method proved to be inappropriate.

For your convenience, a copy of the referral and follow-up forms have been attached. Further information and statistical data concerning this paper may be obtained by contacting the Regional Child Study Services, Drawer AL, Price, Utah 84501.

REGIONAL CHILD STUDY SERVICES FOLLOW-UP FORM NO._____

Drawer AL Price, Utah

TO: _____, Principal Date: _____

FROM: _____, School Psychologist Teacher: _____

SUBJECT: REVIEW OF STUDENT PROGRESS

_____was evaluated on _____.

Your help is needed to determine whether the recommendations made have been effective. Will you please furnish the information requested below to help us make an evaluation of our services?

1. Please indicate the degree of present adjustment in the following behaviors by checking one of the seven blanks.

   a. Educational: satisfactory ___ ___ ___ ___ ___ ___ ___ unsatisfactory

   b. Social: satisfactory ___ ___ ___ ___ ___ ___ ___ unsatisfactory

   c. Emotional: satisfactory ___ ___ ___ ___ ___ ___ ___ unsatisfactory

   COMMENT:

2. To what extent were the recommendations made in the psychological report carried out? Please check and <u>explain</u>.

   ____ unable to follow recommendations
   ____ some carried out (50% or less)
   ____ most carried out (50% to 80%)
   ____ all recommendations carried out (80% to 100%)

3. Is there a need for additional psychological services for this child? (<u>Explain</u>)

   1. ____ Yes
   2. ____ No
   3. ____ New problem

4. Please indicate the degree to which this child is making improvement in initial problem for which referral was made. COMMENTS:

   ____ little or no improvement
   ____ slightly improved
   ____ moderately improved
   ____ generally improved
   ____ greatly improved

5. If student has left your school, please indicate date of leaving, name of school or other placement.

6. Additional comments or suggestions:

PLEASE RETURN THIS FORM BY _____

Name of person completing this form:_____

STUDENT REFERRAL FORM FOR SPECIAL SERVICES

Date _____ 19 _____

Name _____ Date of Birth _____

Grade _____ School _____ Person Making Referral _____

Parents' Names: _____

Address _____ Phone _____

Father's Occupation _____ Mother's Occupation _____

Have parents been contacted and referral approval given? Yes _____ No _____

Reason for Referral _____

_____

_____

Special Services Requested: _____

_____

Teacher

Principal or Counselor

Follow-up Action Taken: _____

_____

_____

_____

White Copy: Special Service Office. Canary: School Pink: District Golden Rod: Specialist